Medical Direction and Practice Board
19-September-2007
Minutes

In Attendance Members: Matt Sholl, Steve Diaz, Jonnathan Busko (for Paul Liebow), David Ettinger, Tony Bock

In Attendance Staff: Jay Bradshaw

In Attendance Guests: Rick Petrie (Operations Rep), Dan Batsie (Education Rep), Jeff Regis, Joe Lahood, Bob Hand, Patty Hesse, Jay Young, Joanne LeBrun, Sephen Bennett, Lisa Buck, Kevin Bachi, Dennis Russell, Robert Hawkes, Alan Azzara, John Brady, Tim Beals (Board Rep), Norm Dinerman, Larry Hopperstead

Topic	**Discussion**	**Action(s)**
1) Introductions	None	None
2) Minutes from July 2007	None	Motion to Accept by Sholl, second by Ettinger, with unanimous approval
3) Legislative and Budget Update	None per Bradshaw	None
4) Cyanokit	To be presented next month	None
5) Annual Goals Update	Diaz presented to MEMS board, no feedback yet.	Diaz will draft letter to board members for feedback on prioritization of our projects.
6) Who can be an EMS medical director?	This question arises from a variety of sources but the most pressing is that of the PIFT program. We did have discussions around this a couple of years ago and the step would have been too large at the time and we decided to embark on an OLMC course and a medical direction course for Maine to help us with this. With PIFT, the discussion is upon us again. Can we use NPs and PAs in this role, especially for PIFT. No national model here and lots of opinion on both sides. The PA in Maine may not delegate authority but can affirm protocols and procedures. The NP can be an independent practitioner or not depending on the board of nursing requirements and licensure. Strong sentiment that Maine struggles with enough available and appropriate physicians and that midlevels could help us. With the PIFT program specifically, strong support for all providers who are appropriate to participate.	Language drafted and accepted as follows with motion by Sholl and second by Bock with unanimous approval: "For the Maine EMS PIFT Program, EMS services must have a service medical director. This person can be a physician, nurse practitioner or physician assistant licensed in the State of Maine. The individual provider will function within their scope of practice. These medical directors will be subject to the policies and rules of Maine EMS." Secondly, Diaz will circulate job descriptions to be provided by Ettinger and/or Busko from previous discussion for discussion next month.
7) Psychiatric Transfers	A crew had a recent assault by a patient against crew member on a voluntary psychiatric transfer. Articles and reports surrounding this previously circulated and Patty Hesse and Jay Young shared this experience with us. As a prelude, Diaz discussed that MDPB has the ability to	Diaz will draft a letter on behalf of the MDPB to ED directors and Nursing Home directors that patient handoffs to EMS crews require the standard of any and all information to be shared with the EMS crews;

	set scope standards on intrafacility transfers but we are not able to dictate hospital practice or transfer practice since hospitals are responsible for intrafacility transfers. MEMS QI has been working for a year on the issue of psychiatric transfers and risk to crews based on the timing of such transfers. In any event, well known that psychiatric care in Maine needs help at levels of the system including EMS crew and EMS system response to this unique need. After the presentation, many issues arose and one of the most disturbing facts is the amount of second guessing by those afterwards towards the crew who was assaulted: "did you violate the patient's rights," " why did you not fling the doors open and run," "why was a women with a man in the back," and other such accusatory statements. Suffice to say that EMS crews work in an uncontrolled environment and may be in situations where the text book answer does not fit, and this could be applied to many aspects here. The issue of medicalizing personality disorders and placing all healthcare providers at risk is also a major issue. Two concrete paths for EMS intervention are complete and appropriate crew handoffs and who/what is the most appropriate way to staff and operate transfer of psychiatric patients.	Diaz will draft letter to MHA and MAA to see if consortium on this issue can be put together to identify and address problems; and MEMS QI will explore whether the timing of transports is a real issue Secondly, Petrie will try to help services with policies around psychiatric transfers. Education is available—no central process for this at the current time—should we engage MEMS Operations—this was not fully discussed. Petrie and Bradshaw agreed to talk with Dispatch leaders about a code to use for EMS crews who are being assaulted. Lebrun suggested a task force—whether to approach MQF or MAA was suggested—firm leader not identified.
8) Central Venous Device Access	This protocol not used very often and update needed since IHI through Don Berwick identified central line infection as a major initiative.	Motion by Busko with second by Sholl to change language in 2008 protocol update to no longer allow the use of central venous device access (clarification—if device all ready accessed, use is OK).
9) Hazmat Events	Hazmat Attachment previously circulated, and some minor language changes made. Where this "would live" was also discussed and a companion book for such things as SOPs from MEMS is probably needed in the future.	Motion by Ettinger and second by Busko to accept **SOP60 Haz-Mat Gross Field Decon ver2.doc**. Bradshaw will have MEMA check this and if all OK, out to service directors with cover letter.
10) Helmet Removal	MEMS Education committee has had a discussion on Gray 27 of MEMS Protocols 2005—it follows the ACSM guidelines which are national guidelines on helmet removal adopted by many health professionals and whose steering committee is multidisciplinary including physicians of many specialties. The final line of our pathway has weaker language than the guidelines and a suggestion is brought to the MDPB to standardize this	Motion by Busko and Second by Ettinger to change final line to read "Leave the Helmet in Place" and this will be updated in the MEMS 2008 Protocol update

	protocol with the national guidelines. Questions of how this fits with national EMS curriculum and books and how it fits ACS were brought up—no firm answer for these questions. Other MEMS protocols do not entirely align with national EMS guidelines or ACS guidelines.	
11) 12 Lead EKG Training Waiver	Document previously circulated to provide a mechanism for those with previous 12 lead EKG training to be in compliance with new 12 lead EKG program. This form can be signed off by service medical director or service educator (eg. Paramedic) or by course lead instructor. Discussion of previous and ongoing courses and how do we know if they are in compliance? Circulating the objectives and allowing for "gap" education is allowable under this system as well. MEMS needs to have a listing of programs which meet the 12 lead educational objectives. The form once completed stays with the service but is available for inspection. Also discussion on form format and "font."	Motion by Ettinger and second by Busko to accept the form—unanimous approval. The form will have formatting changes to try to get it onto one page.
12) OLMC	Busko has received clarifications from Bradshaw and this will be ready for final acceptance at next MDPB	Final program presentation next month.
13) CPAP Update	Batsie circulated CPAP data to date. Trends of improvement in patient physiology noted but not statistically significant. Also, vast majority of cases are CHF which is desired but this specificity is higher than anticipated. Issue of hospitals helping with QI data so we know whether this is helping or not. Discussion to have letter from MDPB to reach out to the hospitals to encourage compliance with our QI. Discussion also if we need to look at EMS statutes to ensure the legal standing of EMS acquiring hospital data for QI—this is reasonable and is the correct standard for establishing evidence-based care, just need to be sure all our rules/statutes are in alignment. If further issues, discussion of involving MHA. Hopperstead he will help at CMMC if given a monthly list.	Diaz will draft letter to hospital ED directors and medical records directors to plead our case. Note to Bradshaw to have legislative analysts look at statutes. Letter will go with PIFT project and forms.
14) Vaccination Program Update	Forms distributed by Busko and discussion of EMS vaccination program for force protection. The project and forms are in alignment with national standards, and some discussion of scope of EMS force coverage.	Motion by Sholl to accept the program and second by Bock, with unanimous approval—to operations council to see if wordsmithing on the scope of EMS force protection is needed and to education as per our process.
15) MEMS QI Report	Today will discuss EMS and psychiatric transfers	None
16) MEMS Education	Batsie reported that they brought the	None

Committee Report	helmet piece to us today, they are working on protocol update and they are working on accreditation and standard for new licensure which will go to operations council	
17) MEMS Operations Committee Report	No report	None
18) Next Meeting October 17, 2007		